

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011214	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/13/2013
NAME OF PROVIDER OR SUPPLIER ACCESS TO CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3645 N BRIARWOOD LN STE D MUNCIE, IN 47304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	<p>Initial Comments</p> <p>This visit was a home health state licensure survey.</p> <p>Survey visit: March 12, 13, and 14, 2013</p> <p>Facility # 011214</p> <p>Medicaid Vendor #: N/A</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor</p> <p>Access at Care, LLC is in compliance with the Indiana State Rules for home health agency licensure 410 IAC Article 17.</p> <p>Private Pay Patients 45</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 15, 2013</p>	N 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

XW4011

If continuation sheet 1 of 1